2003

Drug Wars in Black and White

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Publication: *Law and Contemporary Problems*

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I

INTRODUCTION

Over the past two decades, we have waged war on drugs. Yet it is not likely to be news to any reader of this Symposium on race and criminal justice that the primary casualties of that war have been African Americans and other individuals of color. The debate over the racial complexion of the war against drugs often devolves into a clash of fundamental assumptions that are difficult to either validate or refute. Do we wage the war against drugs in African-American communities because "that is where the drugs are?" Or do we find most illegal drug users and sellers in African-American communities because that is where we spend most of our time looking? Do we punish the sale of crack cocaine so severely because of the effects of the drug or because of the race of those using it most openly?

Critics of the racial disparities of the current effort often point to social science research revealing high illegal drug use among whites.[1] They reason from this evidence that many whites must be engaged in the sales and distribution of illegal drugs given the plausible—and somewhat verified—assumption that people tend to purchase illegal drugs from members of their own race.[2] By failing to go after white users and sellers as aggressively as African-American users and sellers, the system both creates racial disparities in justice and generates a stream of convictions that tautologically confirms the animating premise that illegal drug use is a predominantly "black problem."[3]

There is, of course, a standard rejoinder. Law enforcement naturally and logically focuses on those communities where illegal drug use has created the

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This article is also available at http://www.law.duke.edu/journals/66LCPKennedy.

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Sara Sun Beale, Eric Muller, Robert Mosteller, Maria Savasta-Kennedy, Andrew Taslitz, and Ron Wright all provided very useful feedback on an early paper that formed the basis for this project. Anna Levinsohn provided excellent research support. Molley Clarkson, Shireen Matthews, and the other staff of this journal also provided excellent editorial support.

1. *See, e.g.*, MICHAEL TONRY, MALIGN NEGLECT: RACE CRIME, AND PUNISHMENT IN AMERICA 107–109 (1995) (summarizing survey data showing that whites are more likely to have used cocaine, marijuana, hallucinogens, and alcohol than African Americans).

2. *See* MARC MAUER, RACE TO INCARCERATE 150 (1999) (quoting National Institute of Justice finding that people are more likely to buy illegal drugs from members of their own race).

3. I realize that focusing only on whites and African Americans excludes much. Latinos, for example, are also disproportionately represented in the drug war. *See* TONRY, *supra* note 1, at 109. I do so for space reasons and because African Americans are the prime casualties of the drug war in both absolute and relative terms. *Id.* at 104–05.

most harmful and most visible effects.[4] Selling crack openly in the streets or out of notorious "crack houses" should attract disproportionate attention. Perhaps the predominantly white students of college campuses use as much illegal drugs as denizens of inner city neighborhoods, but drug-related drive by shootings often take place in the inner city and not on college campuses. More generally, illegal drug use is seen as devastating African-American communities in a way that is not seen outside the inner city. People losing jobs, kids dropping out of school, parents neglecting or abandoning their children—all of these social costs are more readily seen in the inner city than in the more affluent white communities where illegal drug use seems to be relatively benign. Even more to the point, illegal drug use in the inner city is seen as crimogenic—the inner-city user of illegal drugs is thought to be more likely to steal or commit some other crime to finance his drug use.[5]

It is difficult to break outside of this simplistic debate because the contemporary data about illegal activity and its consequences are difficult to collect in any way that is both comprehensive and independent.[6] Excellent social science research has challenged some of the assumptions about the nature of drug addiction in the inner cities and its relationship to crime,[7] but the relatively small scale of this research has been drowned out in the public debate by the mind-numbing quantities of statistics generated by the criminal justice system, statistics that purport to validate enforcement decisions to focus on inner city communities of color. Ultimately, however, the criminal justice system is destined to find crime only where it looks for crime.

One way to break out of this debate is to turn to history. Comparisons over time are always imperfect, but they do provide a slightly more detached perspective on matters of controversy, a detachment born of the lower level of investment we feel about social practices in the somewhat distant past. Critics of the current war against drugs often surmise that the war would be waged far differently—or abandoned altogether—if whites were prosecuted and imprisoned more frequently than has been the case.[8] History provides a qualified opportunity to explore this theory.

During the 1920s our government waged a major drug war. It was a two-front war against both alcohol and narcotics. The nation's experiment with Prohibition took place during this time, and the first determined effort to

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4. *See, e.g.*, William J. Stuntz, *Race, Class, and Drugs*, 98 COLUM. L. REV. 1795 (1998).

5. *See infra* at notes 111–16 and accompanying text.

6. Criminal justice statistics are obviously not independent because they embody the assumptions by prosecutors and police that lead to their creation. Social science research, on the other hand, is not comprehensive due to the inherent difficulties of measuring illegal activity.

7. *See generally* CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE (Craig Reinarman & Harry G. Levine eds., 1997).

8. A former police chief for the city of Atlanta put it succinctly:

> If we started to put white America in jail at the same rate that we're putting black America in jail, I wonder whether our collective feelings would be the same, or would we be putting pressure on the president and our elected officials not to lock up America, but to save America.

MAUER, *supra* note 2, at 118 (quoting former Atlanta Police Chief Eldrin Bell).

enforce the Harrison Act, our first national anti-narcotics law, was well underway.[9] This article reveals that the drug wars of the twenties were both far less punitive and far more color-blind than our recent efforts. Compared to the current war on drugs, these first national efforts at substance abuse control involved far less prison time for far fewer people. More to the point of this Symposium, the casualties were primarily white: African Americans were relatively under-represented among those imprisoned for narcotics and prohibition violations during the 1920s.[10]

While such statistics suggest that race plays some role in shaping how punitively drug wars are prosecuted, they do not tell us much about how that influence works. This article also explores how race influences the severity of punishment in our current drug war. Whereas past drug wars have occurred during periods of general moral intolerance, the current war against drugs has broken out of this cycle. Our first war against narcotics in the twenties took place alongside a campaign against the mainstream drug of American society—alcohol. The current war against drugs has taken place during a time when the use of legal drugs has grown explosively. From overcoming shyness to losing weight to enhancing sexual or athletic performance to simply being happier—the 1990s saw a growth in the use of ingestible substances to deal with almost every type of problem imaginable.

In the absence of a strong cultural norm of self-restraint with respect to drug use generally, the justification for the current war against drugs rests heavily on an epidemiological form of morality that turns on the risks of harm that flow from the use of a drug by a given population. Notions about the harmfulness of a drug have always been inextricably intertwined with the race of those who use it, and drug use by minorities is usually seen as more harmful than drug use by whites in our society.[11] The unparalleled severity of the current war against drugs rests, however, on greatly exaggerated notions of harm, particularly with respect to crack cocaine. For all its moralism and quasi-religious fervor, the crucial and inequitable premise of our current drug war is that whites can "handle their drugs" better than African Americans can. The result has been a drug war that is unprecedented in both its punitiveness and in its racially disparate impact—the criminal justice equivalent of total war.

These exaggerated notions of the harms of illegal drug use by African Americans are a perverse result of the liberality with which mainstream society views legal drugs. Our increasingly *laissez-faire* approach to legal drugs has produced profound anxieties about the absence of norms of self-restraint, and mainstream society exorcises those anxieties by overpunishing those who use illegal drugs. Race is the essential lubricant that makes this dysfunctional compromise work. The "otherness" of African Americans and other persons of color enables mainstream society to imagine the use of illegal drugs to be so

9. *See infra* at note 78 and accompanying text.
10. *See infra* at notes 91–110 and accompanying text.
11. *See infra* at notes 142–46 and accompanying text.

much more harmful than legal drugs even though they are increasingly being used for related

purposes.

The remainder of this article proceeds in two parts. Part II provides some background for the drug wars of the 1920s and lays out the statistical case that the drug wars of the twenties were both far less punitive and far less disparate in terms of its impact on whites and African Americans than our current drug war. Part III explores the cultural dynamics of the current war against drugs and the role that race plays in those dynamics. The conclusion briefly touches on the policy implications of this analysis for judges and legislators.

II

THE DRUG WARS OF THE TWENTIES

Comparing complex social phenomena such as drug wars across time is not something to be done casually. One never steps into the same river twice, especially when the two steps are separated by sixty or seventy years. Prohibition and the initial campaign against narcotics were complex events with multiple causes. They were also rooted in their specific historical context in ways that are difficult to disentangle. Yet to abjure historical comparison altogether is to come close to saying that history has nothing to teach us about the present. While drug wars cannot be reduced to a few moving parts that pre-ordain the result, comparison on selected points can yield important insights. Comparison of the drug wars of the twenties with our more recent effort suggests that race influences how severely drug offenses are punished. After providing some relevant historical context, this Part paints a statistical picture of drug and alcohol prosecutions between 1923 and 1932, a ten-year-period that constitutes virtually the entire history of Prohibition enforcement as well as the early period of active enforcement of the Harrison Act,[12] our nation's first national anti-narcotics legislation.

A. America's Early Love Affair with Narcotics

Opium, morphine, and cocaine came into widespread use in the United States during the nineteenth century.[13] Opium consumption in the United

12. Harrison Acts (Narcotics), ch. 1, 38 Stat. 785 (1914).

13. DAVID T. COURTWRIGHT, DARK PARADISE: OPIATE ADDICTION IN AMERICA BEFORE 1940, at 1–101 (1982); LESTER GRINSPOON & JAMES B. BAKALAR, COCAINE: A DRUG AND ITS SOCIAL EVOLUTION 17–45 (1985);); TIM MADGE, WHITE MISCHIEF: A CULTURAL HISTORY OF

States was proportionately higher than in Russia and the major countries of Western Europe.[14] The principal cause of opiate addiction was the prescription by doctors of narcotics in a process known as iatrogenic addiction.[15] Although opium and morphine were used by doctors to treat everything from violent hiccups to masturbation, addiction was most common in those suffering from chronic conditions such as neuralgia, chronic respiratory disorders such as asthma and bronchitis, infectious diseases, rheumatism, chronic diarrhea and various postoperative syndromes. [16]

Some of the medical uses of opiates can perhaps be excused in light of the relatively primitive state of medical science at the time. Indeed, the decline in iatrogenic morphine addiction corresponded with the growing understanding of the roles of germs in causing disease, the importance of sanitation measures, the development of vaccines and forms of chemotherapy against diseases such as syphilis, and improved diagnostic practices.[17] Still, much of the problem flowed from lazy or incompetent practitioners.[18] Even worse, unscrupulous doctors fostered addiction in their middle-class clients out of greed:

> When a 'physician is called for the first time to a well-to-do home,' observed one group of skeptical pharmacists, he realizes that 'a practice might be secured which would be valuable if he can only show his ability, and he does—there is not very much pain in the prick of a needle, and the result is so quick, so calming—wonderful man—the patient begins to improve at once.'[19]

Some doctors referred to addicted patients to asylums or "quack cure joints" in exchange for a substantial kickback.[20]

The demographics of opiate addiction of the nineteenth century United States reflected its roots in medical practices. The typical opiate was a middle-aged white woman of the middle or upper class.[21] The poor were under-represented because they could not afford doctors; the middle-aged were over-represented because they suffered from the sorts of chronic pains and ills that prompted doctors to prescribe morphine or opium; women were over-represented both because of the prevalence of dysmenorrhea and other gynecological disorders and because male doctors of the time were prone to diagnose women as suffering from various "nervous disorders;" southerners were over-represented because of the prevalence of malarial and diarrheal diseases in

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COCAINE 49–83 (2001); DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 1–6 (1999).

14. MUSTO, *supra* note 13, at 1–2.

15. *Id*.

16. COURTWRIGHT, *supra* note 13, at 48.

17. *Id.* at 52.

18. *Id.* at 50 ("Not only was the graduate of a typical proprietary school ill-informed about the danger of repeated administration of opiates, but his general lack of diagnostic skills tempted him to fall back on blind, symptomatic treatment.").

19. *Id.* at 51 (quoting E.G. Eberl et al., *Report of Committee on the Acquirement of Drug Habits*, 51 PROC. OF THE AMERICAN PHARM. ASS'N 472 (1903)).

20. *Id.* at 50 (quoting S. Burnett Grover, *Why the Indifference of the Profession to Morphinism Should Be Changed*, MED. HERALD, n.s. 29 at 328 (1910)).

21. COURTWRIGHT, *supra* note 13, at 1.

their warmer clime.[22] In a morbid irony, African Americans probably enjoyed a lower rate of addiction because they lacked access to medical care and because their shorter life spans precluded many of the age-related chronic diseases for which doctors routinely prescribed opiates.[23]

The prevalence of opiate addiction among white middle-class women was not purely a matter of medical practices, however. The cultural and political plight of women at the time was also an important factor. "[T]here was a powerful temptation, particularly for women of high social station, caught up in the social swirl, for women stranded in rural areas, thoroughly bored with their lot, and for seamen's' wives, separated for long periods from their husbands, to resort to some euphoric agent."[24] Ironically, educated and capable woman may have been among the most vulnerable to this non-therapeutic form of addiction, a vulnerability expressed by one anonymous voice from the time:

> I am the last woman in the world to make excuses for my acts, but you don't know what morphine means to some of us, many of us, modern women without professions, without beliefs. Morphine makes life possible. It adds to truth a dream. . . . I make my life possible by taking morphine. I have managed to prevent it from disfiguring my life, though I know other women who botched it horribly. I am really morphine mad, I suppose, but I have enough will left not to go beyond my daily allowance.[25]

One of the greatest ironies of our society's early experience with addictive drugs was the number of times that one addictive drug would be used as a "cure" or substitute for another. Women turned to opium and morphine in part because it was considered unseemly for a woman to consume alcohol.[26] Alcoholics sometimes became addicted after using opium to mitigate alcohol withdrawal.[27] Perhaps, the greatest example of robbing Peter to pay Paul in early U.S. narcotics history was the use of cocaine and heroine to treat morphine and opium addiction. "Cocaine and heroin were both introduced from excellent laboratories by men with considerable clinical experience who judged them to be relatively harmless, in fact, to be possible cures for morphine and alcohol addiction."[28]

A second irony was that users sometimes switched to a more addictive or powerful drug in response to a legal crackdown on their earlier drug of choice. Heroin got a big boost in the early twentieth century during a crack down on smokable opium: heroin at that time was a legal but regulated narcotic whereas the relatively less potent smoking opium was banned outright.[29] Heroin use also

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22. *Id.* at 49.

23. *Id.* Another telltale sign of iatrogenic addiction may have been the fact that addiction's decline after 1900 coincided with the death of a generation of surviving Civil War veterans, a population plagued by various then-untreatable ailments such as chronic diarrhea and often introduced to opium and morphine for treatment of wounds during the War. *Id.* at 56.

24. *Id.* at 60.

25. *Id.* at 60 (quoting Charles W. Collins & John Day, *Dope, the New Vice*, *in* 5 EVERYDAY LIFE 4–5 (1909)).

26. COURTWRIGHT, *supra* note 13, at 60.

27. *Id.* at 48–49.

28. *Id.* at 5.

29. *Id.* at 83–84, 96.

increased around the same time in response to a crackdown on cocaine, a perverse consequence given that heroin is now considered to be the more addictive drug.[30]

Cocaine came into widespread use in the United States during the latter part of the nineteenth century. It was first made available in the United States in the form of a widely popular wine that contained an extract from the coca leaf.[31] In the late 1870s and early 1880s doctors began to promote it as a cure for opium addiction and pharmaceutical companies began to advertise it as a cure for both morphinism and alcoholism.[32] In 1884 it received a glowing endorsement from Sigmund Freud, a person later judged to have been addicted to cocaine at the time.[33] During that same year numerous important applications of cocaine as an anesthetic were developed.[34] Soon thereafter it was offered as a panacea of sorts for a variety of ailments ranging from head colds to stomach ailments.[35] At one point it even became the official remedy of the Hay Fever Association.[36]

Cocaine was also thought to be an all-purpose cure for a variety of emotional and mental problems. It was used to treat a number of mental illnesses including depression.[37] Most interesting from a cultural point of view was its use to treat the vaguely defined but widely diagnosed condition called neurasthenia.

> Patients with neurasthenia exhibited a dazzling array of sometimes contradictory symptoms: nervous dyspepsia, headaches, sleeplessness, hysteria, allergies . . . drunkenness, even epilepsy. The cause was increasingly attributed to the rate of change in American society . . . Cocaine, it was thought, could 'repair' the damaged and debilitated nerves created by an overheated society.[38]

In its use to treat neurasthenia, cocaine became in essence a "cure" for the ailment of modern life.

Given the almost magical properties attributed to cocaine by the medical profession, it is little wonder that cocaine came to be used widely by the public in a number of commercial applications. In addition to being a common ingredient in soft drinks and wines, it was available in cigarettes, liquors, tablets, hypodermic injections, ointments, and sprays.[39] Bars often put a pinch of cocaine in whiskey, and cocaine was peddled door-to-door in some locales.[40] So called "soft drinks" containing cocaine were a popular alternative to cocaine

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30. *Id.* at 98–99 (describing the switch from cocaine to heroin in response to increasing of the price of and legal restrictions on cocaine); CYNTHIA KUHN EL AL., BUZZED: THE STRAIGHT FACTS ABOUT MOST USED AND ABUSED DRUGS FROM ALCOHOL TO ECSTASY 172–75, 209–11 (1998) (describing the addictive properties of heroin and cocaine).

31. MADGE, *supra* note 13, at 50.

32. GRINSPOON & BAKALAR, *supra* note 13, at 20–21.

33. *Id.* at 21–22 (describing Freud's endorsement of cocaine); MADGE, *supra* note 13, at 57 (stating that little doubt remains that Freud was at one point addicted to cocaine).

34. *Id.* at 22–23.

35. *Id.* at 24.

36. *Id.*

37. MADGE, *supra* note 13, at 59. GRINSPOON & BAKALAR, *supra* note 13, at 24.

38. MADGE, *supra* note 13, at 59–60.

39. MUSTO, *supra* note 13, at 7.

40. *Id.* at 8.

wines in states where alcohol consumption was coming under increasing condemnation. The most popular soft drink containing cocaine was Coca-Cola, which was marketed as a "medicine" that used the "wonder drug" cocaine as a headache remedy and general stimulant.[41]

Beyond merely curing what might ail you, cocaine was widely thought to be capable of enhancing various types of performance. Consider these claims made by advertisers of Metcalf's Coca Wine during the 1890s:

> Elderly people have found it a reliable aphrodisiac superior to any other drink . . . . Athletes, pedestrians and baseball players have found by practical experience that a steady course of coca taken both before and after any trial of strength or endurance will impart energy to every movement and prevent fatigue.[42]

Whether you were a novelist, a musician, an athlete, or a common laborer, cocaine was supposed to make it easier for you to do a better job.[43] Not surprisingly, cocaine was used by employers to get more work out of underpaid and underfed employees. Construction and mine workers, for example, were given cocaine by their employers to "keep them going at a high pitch and with little food."[44] White employers provided it to black workers to supplement low wages, and sometimes as a substitute for food.

One of the most striking features of nineteenth century narcotics use was the "patent medicine craze." Many proprietary medicines that could be bought at any store or by mail order contained morphine, cocaine, laudanum or (after 1898) heroin.[45] Patent medicines owed their popularity to the shortage of doctors in the west as well as to the fervent belief of nineteenth century Americans in self-help.[46] Narcotics were even contained in baby-soothing syrups.[47] Some patent medicines that were marketed as cures for opiate addiction contained opiates themselves.[48] So powerful was the patent medicine lobby that they defeated a series of congressional measures requiring them to disclose the use of narcotics in their products up until the passage of the Pure Food and Drug Act in 1906.[49]

By 1900, the United States had approximately 250,000 narcotics addicts.[50] Yet the tide already may have already begun to turn. Close analysis of import records suggests that opium and cocaine use actually began to decline during the latter part of the century as people became more aware of the dangers of

41. GRINSPOON & BAKALAR, *supra* note 13, at 28.
42. MADGE, *supra* note 13, at 63.
43. GRINSPOON & BAKALAR, *supra* note 13, at 25–27.
44. MUSTO, *supra* note 13, at 8.
45. *Id.* at 3.
46. MADGE, *supra* note 13, at 63.
47. MUSTO, *supra* note 13, at 4.
48. COURTWRIGHT, *supra* note 13, at 58.
49. MUSTO, *supra* note 13, at 4, 22–23. The political power of the patent medicine lobby in the nineteenth century provides what is perhaps the best history-based argument against the legalization of drugs. To legalize a drug is to open the door to the sort of special interest lobbying that prevented nineteenth century consumers from knowing that there was cocaine in their baby's cough syrup.
50. *Id.* at 5.

narcotics use.[51] It is worth noting that in the years immediately before and after the passage of the Harrison Act, several government reports claimed that the rate of addiction was increasing, with one report claiming that there were over a million opiate addicts in the United States.[52] Close analysis of those reports has revealed a range of flaws ranging from simple errors to outright fabrications.[53] Combining data from pharmacy and clinic surveys with import statistics and military medical examinations, one expert estimates the rate of addiction to have gone from a starting point of less than one addict per thousand persons prior to 1842 up to a peak of four and one half per thousand in the 1890s, and then declining significantly to a maximum of somewhere between two and three addicts per thousand by 1920.[54] Even at the peak of addiction in 1890s, there probably were never more than 314,000 opiate addicts in the United States.[55]

The composition of the addict population changed as it declined. Opiate addiction "ceased to be concentrated in upper-class and middle-class white females and began to appear more frequently in lower-class urban males, often neophyte members of the underworld."[56] A doctor's contemporary account in a medical journal published shortly after the passage of the Harrison Act describes the change in the addict population.

> There has been of late years a marked diminution in the number of users of drugs in the middle and upper classes. This change was noticeable long before the Harrison Act was passed. Years ago it was quite a common experience to see patients in the middle walk of life who were addicted to the use of morphine or to the taking of laudanum. Gradually, however, the number of these cases diminished until at present they are quite infrequent. Now and then, however, a confirmed case is still encountered.[57]

The article attributes the decline in narcotic use among the middle and upper classes to a change in attitudes and practices of physicians and to greater public awareness of the harmful effects of narcotics such as morphine and cocaine.[58] This greater public awareness is, in turn, largely attributed to "the general educational movement, which has taken place for almost a generation in our public schools . . . and in our newspapers.[59] The Harrison Act, on the other hand, was described as being "especially effective in reaching the poorer, the hospital and the dependent classes generally and more particularly the degenerate and criminal classes of the tenderloin."[60]

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51. *Id.* at 8–9.

52. COURTWRIGHT, *supra* note 13, at 9.

53. *Id.* at 9–34.

54. *Id*. at 34.

55. *Id*. at 9, 34.

56. *Id*. at 3.

57. Francis Dercum, *Relative Infrequency of the Drug Habit Among the Middle and Upper Classes. Treatment and Final Results*, 1917 PA. MED. J. 362, 362 (1917).

58. *Id*.

59. *Id.*

60. *Id.* The doctor's description of the long-term treatment for addiction was essentially a prescription for "clean living," albeit one that might have been presumed to be beyond the grasp of the working or "lower class."

Narcotics use, then, went in the short space of fifty or sixty years from a widely popular practice enjoying the approval of the social and professional elite to a discredited practice associated largely with the poor and "underclass." Use among the upper and middle classes largely declined without the law's help, and the passage of the Harrison Act followed, not caused, that decline.

B. The Wickersham Commission's Snapshot of Prohibition

Prohibition is both a much better known part of American history and one that defies easy summary. For present purposes, a major government report assessing Prohibition a few years before its ultimate repeal provides some useful context. In response to growing criticism of Prohibition during the 1920s, President Hoover appointed George Wickersham, a former Attorney General, to head a commission that would conduct a "thorough investigation into the enforcement of the prohibition laws."[61] The National Commission on Law Observance and Enforcement included Roscoe Pound and a variety of other legal luminaries and produced a final report in 1931. The Wickersham Commission's report provides a number of interesting points of comparison between Prohibition and the current war against drugs.

One of the points often made about the current drug effort is the need to reclaim communities blighted by drug dealing. The saloon was the analogue of the crack corner in the campaign for Prohibition. "Probably the institution which most strongly aroused public sentiment against the liquor traffic was the licensed saloon."[62] The Wickersham Commission's Report suggested that the saloon was a key reason for both the passage of Prohibition and its failure. The Report noted that Prohibition had been passed by a political coalition between those true believers who demanded total abstinence and those who favored mere temperance. The temperance movement supported Prohibition to abolish "the commercialized liquor traffic and the legalized saloon."[63] Once the saloon was abolished, however, "the situation was changed."

> The abolition of the commercial traffic and the open saloon were so obviously steps in the right direction that for a time many of those holding this view acquiesced in the law or gave it passive support, but as its operations became more manifest and methods and efforts of enforcement developed, this acquiescence or indifference changed into non-observance or open hostility.[64]

> The permanency of a cure depends largely on the subsequent life of the individual. That life should be a simple physiological life with abundant hours of rest, abundant food, a proportionate amount of exercise in the open air and, above all things, a wholesome occupation which takes up the time of the patient for a reasonable number of hours every day. Social diversion, moderate in degree, is, of course, also of value.

Id. at 363. The question the article does not, of course, address is how addiction can be cured among those whose conditions of life will not permit the cure described.

61. H.R. DOC. NO. 71–722, pt. III (1931).

62. *Id.* at 6.

63. *Id.* at 50.

64. *Id.* at 51.

With the elimination of the saloon, the visible public harm that knitted together a coalition between moral conservatives and liberal reformers disappeared.

In marked contrast to narcotics, whose general use had declined both in terms of the quantity and socioeconomic "quality" of its users, the Commission noted that drinking was not only increasing generally but was notoriously common among the well-to-do. The Report conceded that "after a brief period in the first years of the amendment there has been a steady increase in drinking." Particularly distressing to the Commission was the prevalence of prohibition violations amongst the "better part" of society:

> There is a mass of information before us as to a general prevalence of drinking in homes, in clubs, and in hotels; of drinking parties given and attended by persons of high standing and respectability; of drinking by tourists at winter and summer resorts; and of drinking in connection with public dinners and at conventions . . . . It is evident that, taking the country as a whole, people of wealth, business men and professional men, and their families, and, perhaps, the highest paid workingmen and their families are drinking in large numbers in quite frank disregard of the declared policy of the National Prohibition Act.[65]

The notorious nature of the drinking among the well to do was even more troubling. The Commission was particularly "demoraliz[ed]" by the "open or hardly disguised drinking winked at by those in charge in respectable places where respectable people gather."[66]

Interestingly, the behavior of law enforcement during Prohibition raised many of the same complaints of abusive practices that characterize the current drug war. One of the main reasons that Prohibition had gotten off "to a bad start"[67] was the assumption that "constitutional guarantees and legal limitations on agencies of law enforcement and on administration must yield to the exigencies or convenience of enforcing it."[68] According to the Commission, this approach resulted in abusive police practices that created a public backlash against Prohibition.[69]

Given Prohibition's ultimate repeal and widespread unpopularity, it is tempting to imagine that it was never vigorously enforced. In contrast, the Wickersham Commission reported an explosion in federal prosecutions. "[F]ederal prosecutions under the Prohibition Act terminated in 1930 had become nearly eight times as many as the total number of all pending federal prosecutions in 1914."[70] In a reference that now seems quaint, the Commission

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65. *Id.* at 21.

66. H.R. DOC. NO. 71–722, pt. III, at 39.

67. *Id.* at 44.

68. *Id.* at 46.

69. *Id.* ("High-handed methods, shootings and killings, even where justified, alienated thoughtful citizens, believers in law and order. Unfortunate public expressions by advocates of the law, approving killings and promiscuous shootings and lawless raids and seizures and deprecating the constitutional guarantees involved, aggravated this effect. Pressure for lawless enforcement, encouragement of bad methods and agencies of obtaining evidence, and crude methods of investigation and seizure on the part of incompetent or badly chosen agents started a current of adverse public opinion in many parts of the land.").

70. *Id.* at 56.

noted that the result of this huge increase was a "bargain method," in which federal prosecutors made deals with defendants to plead guilty to minor offenses to keep the courts' dockets manageable.[71] The Commission cited statistics showing that while nationally, federal prohibition violators were going to prison in 41.4% of the cases, the rate in major urban districts ranged from 4% to 6%.[72] The result was that in the largest cities, sentences were almost uniformly limited to "small fines or trivial imprisonment."[73]

Ultimately, the Wickersham Commission Report tells a simple but interesting story about Prohibition. The coalition that passed it broke apart once the most obvious harm associated with alcohol consumption—the existence of the saloon—disappeared from view. At that point, the continued consumption of alcohol by the well-to-do doomed any hopes of stigmatizing drinking. People were also greatly troubled by the aggressive tactics of those police agents enforcing the law. Given the continued prevalence of drinking, an enormous number of arrests were made, but the government never expanded the capacity of the court system to deal with the resulting volume.

C. Crime Rates and Sentencing Practices

Before delving into the statistical details of the drug wars of the twenties, a few caveats are in order. Trends in sentencing practices and in the general crime level were different in the twenties than they were in the eighties. Our first drug wars took place during a time when our rates of crime and incarceration had been relatively stable. The overall rate of incarceration had varied from 98.7 per 100,000 members of the population in 1880 up to 107.9 in 1910 and back down to 94.6 in 1923.[74] From 1910 to 1923, the picture is more mixed. There was an overall increase in commitments for violent crimes such as robbery, rape, and homicide, but an even greater decrease in commitments for minor offenses such as assault, larceny and burglary.[75] In contrast, the overall rate of incarceration per 100,000 members of the population went from 160 in 1972 to 645 per 100,000 in 1997.[76] The decade preceding our current drug war, the seventies, saw a significant increase in crime overall and in street crime in particular. To the degree that our earlier drug wars were less punitive than our current effort, one possible explanation is that we recently have simply been more concerned about crime in general.

This may be part of the explanation, but it is only part. First, as mentioned above, the most serious types of violent crime had been on the increase from 1910 to 1923. Second, sentences for non-drug and alcohol related crime during

71. *Id.*

72. H.R. DOC. NO. 71–722, pt. III., at 56.

73. *Id.*

74. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, PRISONERS 1923, at 7 (1926) [hereinafter CENSUS 1923]. These figures exclude those incarcerated for failure to pay fines, the majority of which may be presumed to have been incarcerated in county jails for relatively brief periods of time.

75. *Id.* at 29.

76. MAUER, *supra* note 2, at 16, 19.

the twenties do not seem particularly lenient. Of those male offenders convicted of robbery in 1930 and receiving definite sentences, 5.5% received sentences of less than two years; 17% received sentences of between two and five years; 27% received sentences between five and ten years; 35% received sentences between ten and twenty years and 13% received sentences in excess of twenty years.[77]

Even more importantly, drug use and crime do not seem to have been connected in the way that they are today. For example, the one relationship between the two noted in the 1923 Census Report was a perverse one. The passage of Prohibition and the Harrison Act was credited with reducing property crime by diverting habitual criminals from property crime to the "increasingly profitable" pursuits of liquor and drug selling.[78] Drug use was apparently not seen as "crimogenic"—as engendering crime—in the same way that it is today. So, less crime overall would not have necessarily meant less punishment for drug use. Of course, drug use may not have been seen as crimogenic because whites were seen as the primary narcotics users, which would suggest that race played a role in the lesser severity of the drug wars of the twenties.

The second important caveat to a comparison of the drug wars of the twenties and the eighties concerns sentencing practices. Indeterminate sentencing was increasingly popular for non-drug offenses. The census report noted that "[t]he high percentage of indeterminate commitments for the chief gainful offenses against property shows that replacement of the definite term sentence by the indeterminate sentence has occurred to an exceptional extent for these offenses which are characteristic of the habitual or professional criminal."[79] Once again, we see in this interpretation of the data a hint of a very different way of looking at things than that which currently prevails. According to our current mindset, determinate or definite sentencing practices are apt mechanisms for dealing with the habitual criminal. The crime determines the time because the repeat offender deserves little of the sort of sentencing mitigation that we associate with indeterminate sentencing. In contrast, the decade from 1910 to 1920 saw the growth of indeterminate sentencing as the weapon of choice against the repeat offender. Apparently, indeterminate sentencing was seen primarily as a way of aggravating sentences against habitual offenders.

Here we see a hint of a very different way of looking at both crime and judicial discretion. Whereas the public currently does not trust judges to punish repeat offenders in the absence of mandatory minimums, three strikes laws, and

77. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, PRISONERS IN STATE AND FEDERAL PRISONS 1929–30, at 23 (1930) [hereinafter CENSUS 1929–30]. Admittedly, the picture changes a little when you look at actual time served. Among those discharged for robbery, 10% served less than a year, 22% served between one and two years, 18% served between two and three years, 12% served between three and four years, 8.7% served between four and five years, and 23% served between five and ten years. *Id.* at 42.

78. CENSUS 1923, *supra* note 74, at 31.

79. *Id.* at 119.

other sorts of determinate sentencing mechanisms, judges in the twenties were trusted to do exactly that. This use of indeterminate sentencing also suggests something about the levels at which definite sentences were set. While determinate sentences are today set with the most culpable offenders in mind,[80] definite sentences for these property offenses at the beginning of the twenties must have been set with the non-habitual offender in mind. Otherwise, why would it have been necessary to target these areas of habitual criminal activity for the use of indeterminate sentencing?

D. A Statistical Overview of Drug Sentencing

Relatively few people were imprisoned during our first drug wars. In 1923, there were only 848 drug offenders and 122 liquor law violators in federal prison.[81] Nationwide there were 203 drug offenders and 1,069 liquor law violators in state prisons.[82] These are very small numbers, even given that the total population of the country at that time was only 111 million people.[83] Converting these raw numbers to per capita figures, of course, makes historical comparison easier. Adding all forms of incarceration together, there were 3.1 persons per 100,000 incarcerated for drug offenses and 16.6 persons incarcerated for Prohibition offenses in 1923.[84] In 1923, not many people were serving what we today define as "hard time" for substance abuse offenses in this country.[85]

The length of sentences for liquor law and drug violators was typically quite low. Seventy-seven percent of all determinate prison sentences for liquor law violations were less than two years in duration.[86] With respect to indeterminate sentences, 61% of liquor law violators were given sentences with a maximum

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80. *See generally* Joseph E. Kennedy, *Monstrous Offenders and the Search for Solidarity through Modern Punishment*, 51 HASTINGS L.J. 829 (2000).

81. CENSUS 1923, *supra* note 74, at 32.

82. If you add in the numbers of those serving time in other penal institutions such as reformatories and county jails, the overall number of drug offenders locked up in state and federal institutions adds up to slightly over 3,000 and slightly over 18,000 liquor violators, but the vast majority of those offenders were, by definition, serving relatively short sentences. *Id.*

83. U.S. CENSUS BUREAU, HISTORICAL NATIONAL POPULATION ESTIMATES, JULY 1, 1900 TO JULY 1, 1999 (2000), *available at* http://www.census.gov/population/estimates/nation/popclockest.txt (last visited March 18, 2003).

84. CENSUS 1923, *supra* note 74, at 41.

85. In contrast, Michael Tonry identifies drug offenses as "the single most important cause of the trebling of the prison population in the United States since 1980." TONRY, *supra* note 1, at 81. From 1990 to 1999 the number of drug offenders in state prison increased by 69% from 148,600 to 251,200. U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS AND FACILITIES (2000), *available at* http://www.ojp.usdoj.gov/bjs/dcf/ correct.htm (last visited Aug. 8, 2002) [hereinafter CORRECTIONAL POPULATIONS AND FACILITIES]. The number of defendants convicted of drug possession offenses in federal court increased by 134% from 1981 to 1991, and the number of defendants convicted of drug trafficking and possession offenses in federal court during that same period increased by 190%. U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, DRUGS AND CRIME FACTS, 1994, at 21 (1994) [hereinafter DRUGS AND CRIME FACTS]. In 1991, 25% of state prisoners and 56% of federal prisoners had been convicted of drug charges (compared to 6.4% of state prisoners and 25% of federal prisoners twelve years earlier in 1979). TONRY, *supra* note 1, at 113.

86. CENSUS 1923, *supra* note 74, at 136.

length of less than two years.[87] The vast majority of drug offenders also received relatively light prison sentences. Of those receiving definite sentences, 59.5% received sentences of less than two years, and 35.6% received sentences of two to four years.[88] In contrast, in the early stages of the drug war in 1991 the average prison sentence for a federal drug offense was just over seven years, and the average prison sentence for a drug offense in state court was a little over six years (although actual time served for state court offenders averaged just under two years).[89]

Good time reductions substantially mitigated the sentences of both drug and liquor law offenders in the twenties. Of those released upon expiration of their sentence in 1923, no drug or prohibition offenders served sentences of five years or more; 3.1% of drug offenders and 2.0% of prohibition offenders served from two to four years; 28.9% of drug offenders and 35.9% of prohibition offenders served sentences of one year; and 67.6% of drug offenders and 62% of prohibition offenders served less than a year. Overall, the chance that an alcohol or drug offender would actually spend only a year or less in custody was better than 90%.[90]

E. Race and the Drug War

Racial disparities among those incarcerated in 1923 certainly existed, albeit to a lesser extent than during the late eighties and early nineties. In 1923, whites constituted 67% of those incarcerated in prisons and jails, and African Americans constituted just 31%.[91] At that time whites constituted 90% of the overall population and African Americans 9%.[92] Still, such a level of racial disparity today among those incarcerated would be welcomed as a great improvement over recent levels. In 1990, whites were incarcerated at a rate of 289 per 100,000 and African Americans were incarcerated at the rate of 1,860 per 100,000, a ratio of over 6:1 in favor of incarceration of African Americans.[93] By

87. *Id.* at 137.

88. *Id.* at 138. During a time when parole was relatively common, drug offenders and liquor law violators were less likely to be paroled. Whereas only 9.4% of drug law violators and 21.7% of prohibition violators were paroled, the parole rates for those convicted of robbery, rape, burglary and larceny were all slightly over 60%. The census report noted however a positive correlation between length of sentence and probability of parole: it specifically attributed the small rates of parole for drug and alcohol offenders to the brevity of their sentences. *Id.* at 162–64.

89. DRUGS AND CRIME FACTS, *supra* note 85, at 19.

90. Reductions in sentence through "good conduct" credits for time served was common for all categories of crime during this time. *Id.* at 164. For example, less than half of all prisoners sentenced to definite sentences of five years or more served five years or more. *Id.* at 168. Of prisoners serving indeterminate sentences with maximum terms of five years or more, only 6% served five years or more. *Id.* at 169.

91. CENSUS 1923, *supra* note 74, at 60.

92. *Id*. Between 1910 and 1920 the relative percentage of African Americans committed to prisons and reformatories had actually gone down although the relative percentage of those committed to jails and workhouses had gone up slightly. *Id.* at 61.

93. TONRY, *supra* note 1, at 61.

the mid-1990s, half of the state and federal prison population was African American in contrast with their 13% share of the national population.[94]

Even at this lower level of representation in the prison population, the percentage of African Americans committed for violations of drug or prohibition laws in 1923 was half that of their overall representation in the prison population and was far less than that of whites. Only 17% of those committed for prohibition violations were African American, compared to 55% native white and 23% foreign-born white.[95] Just 20% of those committed for drug law violations were African American, compared to 55% native white and 14% foreign-born white.[96] Not only did African Americans play a relatively small role in drug and Prohibition incarcerations, such incarcerations had a relatively small impact on the African-American population. Just 2% of African Americans committed to prison were drug law violators and only 8% were Prohibition violators.[97] While African Americans were smaller players in the criminal justice system in 1923 in general, they were bit players in the war against drugs and alcohol.

In contrast, drug offenses accounted for 27% of the increase in the numbers of African Americans in state prisons during the 1990s, as opposed to a 14% increase for whites.[98] Among state prisoners in 1991 African Americans were twice as likely to be serving time for a drug offense.[99] Drug offenses are the principal cause of the 6:1 ration of black versus white incarceration relative to their share of the population mentioned earlier.[100]

F. The Late Twenties

The end of the twenties saw a last gasp effort to invigorate Prohibition enforcement and a simultaneous drop in the levels of incarceration for drug offenses.[101] The years 1929 and 1930 showed a near doubling in the numbers of prohibition prisoners and a decrease of almost a third in the number of drug

94. MAUER, *supra* note 2, at 124. The disparity that occasioned the greatest comment in 1923 was not race but national origin. The Census Report noted a disproportionately large percentage of foreign-born whites incarcerated given their relative share of the population, a disparity that was attributed to the larger presence of foreign-born whites in the cities. CENSUS 1923, supra note 74, at 59.

95. CENSUS 1923, *supra* note 74, at 68.

96. *Id.*

97. *Id.* The report gives an interesting "snapshot" of race and crime.

> [N]ative white prisoners formed an exceptionally high percentage of the total number convicted of forgery (75.9), violating traffic laws (69.8 per cent), adultery (64.2 per cent), and robbery (64.1 per cent). The foreign-born white made up unusually high proportions of the total prisoners convicted, respectively, of non-support or neglect of family (25.4 per cent), drunkenness (24.2 per cent), and disorderly conduct (20.5 per cent). Negroes formed exceptionally high percentages of the totals convicted, respectively, of gambling (64 per cent), carrying concealed weapons (51.4 per cent), assault (43.9 per cent), fornication and prostitution (43.7 per cent), and homicide (41.5 per cent).

Id.

98. CORRECTIONAL POPULATIONS AND FACILITIES, *supra* note 85, at 5.

99. DRUGS AND CRIME FACTS, *supra* note 85, at 1991.

100. TONRY, *supra* note 1, at 110.

101. In 1929, Congress increased the maximum penalties for most prohibition violations. *See generally* KENNETH M. MURCHINSON, FEDERAL CRIMINAL LAW DOCTRINES 10 (1994).

offenders imprisoned. The number of male prohibition offenders imprisoned increased from 6.0 per 100,000 of population in 1928 to 12.6 in 1930.[102] During the same two years, the ratio of male drug offenders imprisoned dropped by almost a third from 3.5 to 2.5 per 100,000.[103] Time served, rather than sentence imposed, provides an even clearer picture of the continued leniency of drug sentencing during the twenties. Of those prohibition offenders discharged in 1930, 70% had served less than a year, 26% had served between one and two years, and 23% had served between two and three years.[104] Of drug violators discharged from custody in 1930, 30% served less than one year, 44% served between one and two years, 14% served between two and three years, 7.4% served between three and four years, and 2% served between four and five years.[105]

The racial complexion of Prohibition and drug offenders changed little at the end of the decade. If anything, the percentage of African Americans involved in prohibition and narcotics violations seemed to have dropped a bit. Among prohibition violators incarcerated that year, 73% were native white, 8.7% were foreign-born white, and 13% were African American.[106] The percentages among drug offenders were 58% native white, 7.2% foreign-born white, and 23% African American.[107]

Most importantly, the 1932 Census Report permits direct comparisons of sentences of offenders of different races for the same type of offense. For the first time, the census report contained a table that correlated average length of sentence with both offense and race. The average definite sentence for drug offenders was 26 months, the same average sentence for African Americans and whites. The average definite sentence for foreign-born white drug offenders, however, was 35 months. The average definite sentence for all Prohibition offenders was 19 months, for native whites 20 months, for African Americans 18 months, and for foreign-born whites 17 months.[108]

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102. CENSUS 1929–30, *supra* note 77, at 10.

103. *Id.* The ratio had briefly spiked up to 4.4 in 1929. The ratios for female drug and prohibition offenders showed little or no movement during the same two years. *Id.* These years also saw a distinct shift back toward determinate sentencing overall. For example, in 1926 the ratio of indeterminate sentences was 1.26 to 1; by 1930 the number of determinate sentences slightly exceeded indeterminate sentences. *Id.* at 19–20. The lengths of these definite sentences averaged slightly higher for prohibition violators and slightly lower for drug offenders compared to earlier in the decade. In 1930, of those 6,268 male prohibition violators receiving definite sentences, 64% received sentences under two years, 31% received sentences between two and five years, 4% received sentences between five and ten years, and less than 1% received sentences in excess of ten years. In 1930, of the 1,403 male drug offenders receiving definite sentences, 50% received sentences under two years, 40% received sentences between two and five years, 8% received sentences between five and ten years, and 1% received sentences in excess of ten years. *Id.* at 23.

104. *Id*. at 44.

105. *Id.*

106. *Id.*

107. *Id*.

108. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, PRISONERS IN STATE AND FEDERAL PRISONS AND REFORMATORIES 1932 21 (1932) [hereinafter CENSUS 1932].

While the average sentences for drug and alcohol crimes during the twenties given blacks were either the same or less than the sentences given whites, African Americans probably serve much longer sentences than whites in the current war against drugs. The mechanism for this disparity in federal cases is the notorious sentencing distinction between powder and crack cocaine. Ninety percent of crack defendants are African American,[109] and federal sentences in crack cases are between three and eight times longer than sentences for comparable powder offenders."[110]

III

THE EPIDEMIOLOGICAL MORALITY OF THE CURRENT WAR AGAINST DRUGS

What accounts for the difference in the severity of punishment given between our first and current drug war? Race clearly plays a part, but what part? Are the racially disparate sentences served a matter of simple coincidence or simple racial animus? Between the equally unlikely poles of coincidence and animus lies a range of possible explanations. One explanation emphasizes the tendency of law enforcement to focus its attentions where enforcement is easiest and where social harms appear to be concentrated. Another explanation emphasizes cultural politics and the cyclical nature of vice wars. Both explanations afford race a somewhat incidental role. Both accounts, while correct insofar as they go, do not adequately explain the long years of prison time meted out to contemporary drug offenders. After reviewing these explanations, I argue in this part that the hyper-punitiveness of our treatment of illegal drugs such as cocaine is in part an attempt to compensate for our increasingly unrestrained reliance on legal drugs to serve an ever growing variety of needs and wants, and that race plays an integral role in that process.

A. The Dynamics of Drug Enforcement Theory

William Stuntz has argued that the racial disparities of the current drug war are best explained by the dynamics of law enforcement: Law enforcement naturally tends to focus vice enforcement on areas where enforcement is easiest and where the social harms flowing from the vice activity are greatest.[111] Stuntz elaborates the useful distinction of upscale versus downscale vice markets. Downscale vice markets in lower-income communities are easier for law enforcement operatives to penetrate than upscale markets that cater to more

109. David Sklansky, *Cocaine, Race and Equal Protection*, 47 STAN. L. REV. 1283, 1289 (1995).

110. United States v. Armstrong, 517 U.S. 456, 478 (1996) (Stevens, J., dissenting) (citing U.S. SENTENCING COMM'N, SPECIAL REPORT TO CONGRESS: COCAINE AND FEDERAL SENTENCING POLICY 145 (1995)).

111. Stuntz, *supra* note 4, at 1795. For a seminal article on the closely related issue of the racial disparities flowing from sentencing distinctions between crack and powder cocaine, see Sklansky, *supra* note 109.

affluent customers.[112] Arresting crack dealers in open-air drug markets is easier than arresting college students operating out of dormitory rooms. Furthermore, downscale markets tend to be more violent and are more likely to be connected to other harmful social pathologies than upscale markets. College drug dealers are not likely to engage in drive-by shootings to resolve turf disputes.

Stuntz supports his argument with historical examples from drug, gambling, and prostitution enforcement earlier in the last century.[113] The racial disparities of the current drug war are in Stuntz's account serious problems in need of redress, but they are ultimately incidental to the underlying dynamics of law enforcement that shape drug enforcement.[114]

While convincing insofar as it goes, Stuntz's system-based explanation does not adequately explain the severity of the current war against drugs. Given that law enforcement has always focused on downscale markets, why are casualties in the current war serving sentences that are so much longer than those served in the twenties? One possible explanation might be that we are simply living in a more punitive time than our 1920s counterparts, but this does not seem to necessarily be the case with respect to all categories of crime.[115] Another explanation might be that the social harms of current downscale drug markets are much greater. This, too, is questionable. Stuntz himself alludes to the ravages of alcohol abuse among earlier generations,[116] and the only difference between the machine gun street battles of the Prohibition era and the drive by drug gang shootings of our own is probably the number of bullets per second fired. Still, the social harm attendant to inner city drug use today may be perceived by society to be greater than those of yesteryear. The remaining question, of course, is why is this so and what role race plays in these perceptions. I address these questions in the sections that follow.

B. The Cyclical Theory of Drug Wars

Students of our nation's drug wars such as Lawrence Friedman, David Musto, and Michael Tonry have all embraced a cyclical theory of drug wars.[117] These cycles link drug wars to larger cultural trends of which drug use is a part. In simple terms, after we as a society binge on narcotics or other vices, we purge ourselves by engaging in zealous prosecution until we have worked our collective guilt and anxieties out of our system. Race plays a key part in this account. Because the purge takes place after mainstream America completes its binge, drug wars get underway only after predominantly white upper- and middle-class America has reduced its level of consumption of drugs. Those left using drugs

112. Stuntz, *supra* note 4, at 1804–15.

113. *Id.*

114. *Id*. at 1825–32.

115. *See infra* at note 76 and accompanying text.

116. Stuntz, *supra* note 4, at 1842 (describing "horrible" consequences of urban saloon life, includng "ruined lives, domestic violence, and crime").

117. *See* LAWRENCE FRIEDMAN, CRIME AND PUNISHMENT IN AMERICAN HISTORY 125–40 (1993); TONRY, *supra* note 1, at 91–94; MUSTO, *supra* note 13, at ix to xii.

during the purge are largely the poor, and the presence of large numbers of people of color among them facilitates—and for some undoubtedly motivates—the dysfunctional scapegoating described. Drug wars in this account are a sort of transferable hangover: When White America over-indulges in drugs, Black America gets the hangover.

The inception of our current drug war neatly fits this pattern. The best evidence suggests that the use of illegal drugs in general and of cocaine particular was in decline *before* the current war against drugs was launched.[118] The current drug war was, as Michael Tonry has so strikingly put it, like Argentina's declaration of war against Germany in 1945: too late and beside the point.[119] In Tonry's account, the racial consequence of the current drug war was a matter of "malign neglect," clearly foreseeable and in that sense the product of deliberate (and morally wrong) indifference, but not a matter of deliberate design.[120]

The current drug war is out of synch with this cyclical theory in a very important way, however. The late 1980s and all of the 1990s can hardly be seen as periods of puritanical retrenchment on moral issues generally. More specifically, the 1990's have seen a dramatic expansion in the use of legal drugs and drug-like substances to accomplish some of the same purposes for which people use illegal drugs.[121] This contradiction reveals an even more dysfunctional, and potentially more sustainable, version of the earlier binge–purge cycle. Mainstream society now gets to binge and purge at the same time. Others who have commented on this paradox have predicted that the "cultural contradictions" of this form of "selective prohibitionism" will in the long run undermine the support for the war against drugs.[122] I argue below that the reverse may be true. As White America moves onto ever wider and greater uses of legal drugs, it may be assuaging anxieties about this trend by overpunishing those left using illegal drugs, a tradeoff that could make the current war against drugs a more durable enterprise than previous drug wars.

Race may well play an essential—and not at all incidental—part in this new variation on the old American theme of periodically using illegal drugs as scapegoats for larger social anxieties. The potential friction between our exaggerated views of the harms of illegal drugs and our relatively *laissez-faire* attitudes towards legal drugs is lubricated by race in a way that seems indispensable.

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118. TONRY, *supra* note 1, at 83–104.

119. *Id.* at 83.

120. *Id.* at 104–05. The racial disparities among those imprisoned also offer an alluringly simple explanation of our drug wars' duration and intensity: The darker the complexion of those imprisoned, the greater the willingness to imprison for longer periods of time. This indifference to the incarceration of other races is only part of the answer, however, as I will argue below.

121. See *infra* at notes 124–30 and accompanying text.

122. Craig Reinarman & Harry G. Levine, *The Cultural Contradictions of Punitive Prohibition*, *in* CRACK IN AMERICA, *supra* note 7, at 334 [hereinafter Reinarman & Levine, *Cultural Contradictions*].

C. The Legal Drug Binge of the 1980s and 1990s

People in our society have always consumed drugs to artificially manage their mental and emotional states. People legally consume alcohol to become more convivial, caffeine to become more alert, and nicotine to feel calm.[123] People also use legal and illegal drugs to escape undesirable mental states such as sadness, anxiety, fear, lethargy, despair, and even simple boredom. The 1990s saw explosive growth in the use of all manners of legal drugs and drug-like substances to address a very wide range of human needs. Even more importantly, the way in which those products were advertised and promoted often appealed to some of the same cultural norms that support illegal drug use.

During the first decade of our war against illegal mood-altering drugs, our use of legal mood-altering drugs exploded. Between 1987 and 1997, the percentages of outpatient psychotherapy patients using prescribed antidepressant medications, mood stabilizers, and stimulants tripled.[124] During this same period of time, the number of people going to physicians (who can prescribe medication) as opposed to psychologists and other non-physicians (who generally cannot) went from roughly one-half to two-thirds.[125] The number of psychotherapy patients receiving psychotropic medications overall increased from one-third in 1987 to two-thirds in 1997.[126]

Prozac is an interesting case in point. The first of a new class of drugs prescribed for mood disorders, Prozac was primarily responsible for a 50% increase in the number of prescriptions of mood-altering drugs by psychiatrists in the 1980s.[127] The uses of Prozac have been incredibly varied. "It is taken by people who feel too 'down' or too 'up,' for various forms of depression, obsessive-compulsive disorders, anxieties, attention deficit disorders, general malaise, and a growing array of other 'conditions' that a decade ago were considered within the normal range of human mood and personality variation."[128]

Considering the following advertisement for Prozac appearing on a web site maintained by the company that manufactures it:

> Do you have a hard time enjoying the things you used to? Do you frequently feel overwhelmed? Have uncontrollable feelings of guilt or worthlessness and lack motivation? Find it difficult to concentrate? Notice that you're sleeping too little? Many of the signs of depression are easy to miss.[129]

This description obviously matches a great number of people who might simply be unhappy or anxious for some bona fide reason, but the text of the advertisement goes on to warn them that such a person may actually be clinically

123. KUHN, *supra* note 30, at 155,

124. Mark Olfson et al., *National Trends in Outpatient Psychotherapy*, 159 AM. J. PSYCHIATRY 1914 (2002).

125. *Id.*

126. *Id.*

127. Reinarman & Levine, *Cultural Contradictions*, *supra* note 122, at 337.

128. *Id*. at 338.

129. Welcome to Prozac.com: Your Guide to Evaluating and Recovering from Depression, *at* http://www.prozac.com (last visited May 1, 2003).

depressed if they have been suffering from these symptoms for two weeks or more.[130]

While clinical depression would at least strike most people as a clear medical condition, prescription mood-altering drugs have also been advertised as addressing mental states that have not traditionally been thought of as medical problems. Paxil, for example, is currently being advertised for use in treating both shyness and "general anxiety disorder."[131]

Peter Kramer, author of the best-selling book, *Listening to Prozac*, has described certain medical uses of Prozac as a form of "cosmetic psychopharmacology" by which relatively normal patients achieve the personality of their choice.[132] He describes the use of Prozac by people under pressure at work to help them think faster as a form of "steroids for the business Olympics," a use that constitutes "according to our point of view, legitimate enhancement, legalized cocaine, or a neurochemical nose job."[133] Kramer notes that "we are entering an era in which medication can be used to enhance the functioning of the normal mind."[134]

Kramer does not make any empirical claims about the degree to which Prozac is being used as a performance enhancer or as a personality modifier. Rather he simply points out that Prozac carries the potential for cosmetic use and that such potential raises profound ethical and normative questions. The popularity of Prozac undoubtedly owes much to the fact that it is a more effective treatment for clinical depression and that the stigma attached to psychoactive medications generally has finally begun to lift. Under an older view, mental illnesses such as clinical depression were seen as character defects or moral failings instead of as medical conditions. Kramer's discussion of Prozac raises the possibility that we may be swinging from one extreme to another: from irrationally stigmatizing the use of psychoactive medication to deal with mental illnesses to celebrating their use as a "magic pill" to modify personality traits such as shyness or lethargy, traits that have not traditionally been seen as medical problems and whose status as a "problem" at all turn on culturally driven assumptions about what variations the baseline of a "normal personality" includes.[135]

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130. *Id*. Obviously, people suffering from clinical depression should be medicated. Ironically, at the same time that pharmaceutical companies are pushing use of these drugs for relatively minor problems, many people who are clinically depressed go untreated. *See e.g.*, Myrna M. Weissman, *Review of "The Antidepressant Era,"* 338 NEW ENG. J. MED. 20 (1998).

131. APA: Paxil (Paroxetire) Effective in Treating Generalized Anxiety Disorder, *at* http://www.inhousedrugstore.com/anti-depressants/paxil2.html (May 15, 2000); Paxil, First Antidepressant Cleared by FDA for Panic Disorder, *at* http://www.inhousedrugstore.com/anti-depressants/paxil4.html (May 7, 1996).

132. PETER O. KRAMER, LISTENING TO PROZAC 245–49 (1993).

133. *Id.* at 246–47.

134. *Id.* at 247.

135. Unfortunately pendulums tend to swing back, and one danger of the current laissez faire attitude towards psychoactive medication is that we may at some point in the future once again stigmatize all uses of such drugs. The other danger, which I address below, is that the process of overcoming the stigma against the use of psychoactive medication to treat mental illness has resulted in

This use of mood-altering drugs to alter personality traits that are not themselves traditional symptoms of mental illness is part of a larger trend described by many commentators as the medicalization of problems.[136] Douglas Husak has used drugs designed to enhance sexual performance to illustrate the blurriness of prevailing distinctions between medical and recreational uses of drugs. One such drug enhances male sexual performance by acting directly on the brain (unlike Viagra). The other claims to enhance sexual pleasure for either men or women. Husak argues that both drugs, especially when used by men or women for non-reproductive purposes, are essentially recreational drugs that are being marketed, financed and (lightly) regulated as medicine.[137]

Aside from the exploding use of prescription drugs that are heavily advertised by the pharmaceutical companies that make them, a variety of over the counter drugs and drug-like substances are being offered as easy ways of meeting difficult needs. The elderly are advised to take Advil to help them ignore the aches of age. The overweight (or simply the vain) are told that the new diet pills will allow them to lose weight without having to exercise. One reported survey claims that 40% of American boys twelve and over have used or plan to use anabolic steroids to improve their physique or athletic performance.[138] Children that have behavioral and learning problems are increasingly being medicated with drugs such as Ritalin. Some drug-like substances do not even have to be approved by the Federal Drug Administration because they are considered herbal supplements.[139] Ephedrine, for example is considered an herbal supplement and is widely marketed as a weight-loss aid and as an athletic performance enhancer even though there have been a number of deaths resulting from excessive doses.[140]

The comparisons with the nineteenth century could not be more obvious. Enhancing sexual and athletic performance, increasing one's ability to concentrate and get work done, managing mood—many of the reasons that people are using legal drugs are similar to the reasons that drove cocaine consumption in the late nineteenth century. The use of mood-altering drugs to help people tailor their personalities to the needs of the time sound suspiciously like the use of opiates and cocaine to treat the vaguely defined (and no longer clinically respected) nineteenth century syndrome neurasthenia. The willingness of some

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some free floating anxiety about mood altering substances generally, an anxiety that has exacerbated the punitiveness of the current war against drugs.

136. DOUGLAS HUSAK, LEGALIZE THIS! THE CASE FOR DECRIMINALIZING DRUGS 40 (2002).

137. *Id.* at 40–43. The thinness of the difference between our legal and illegal drugs in some cases is striking. The widespread use of Ritalin has been criticized by many doctors as nothing more than legalized cocaine for kids. *Id.* at 68. Prozac, Paxil, and all of the other serotonin-specific uptake inhibitors, known as SSRI's, exploit the same chemical pathway as the illegal drug Ecstasy; they just do so in a much more limited way that avoids the possible brain damage linked to Ecstasy. KUHN, *supra* note 30, at 73.

138. HUSAK, *supra* note 136, at 36. Such use, of course, is illegal because it is considered a "non-medical" use of the drug. *Id.*

139. KUHN, *supra* note 30, at 134.

140. *Id.* at 105.

psychiatrists to write prescriptions for such purposes and their aggressive marketing by pharmaceutical companies raise the spectre of a new wave of iatrogenic (doctor-created) addiction. The eagerness to use untested and unregulated herbal supplements neatly parallels the patent medicine craze. Depending on your point of view, we are either in the grip of a new wave of quackery or on the verge of a brave, new, pharmaceutically improved world.

What is different, of course, is that we were not simultaneously imprisoning legions of people for taking the wrong drugs during the nineteenth century. Understanding how this paradox flourishes requires attention to the relationship between drugs and some of the dominant cultural norms of the 1980s and 1990s.

Drug use in the United States has always been consonant with powerful themes in our culture. Consumerism supports drug use as simply one more purchase that can make our lives better. Self-realization, super-achieving, and simply being happy are all things that our culture celebrates, and drugs are easily portrayed as efficient means to these ends. The desire to believe in the ability of drugs to cure life's more intractable problems fits in nicely with our cultural tendency to embrace scientific or technological solutions to problems that might otherwise require sacrifice, suffering, or hard work.

These cultural tendencies to idealize drug use were usually counterbalanced, however, by other cultural norms of self-restraint, self-reliance, or—where the substance was legally prohibited or socially discouraged—deference toward authority. In contrast, the culture of the 1980s and 1990s celebrated self-realization, super-achievement, and super-happiness. Being willing and able to satisfy your every desire was seen as a sign of success, not weakness.

Situated within this larger social context, it is not surprising that the use of drugs to satisfy every possible need was not, and is not, seen as bad in and of itself: Drug use is seen as bad only if it causes a problem. Under an older, more traditional, view recreational drug use and other diversionary vices were simply immoral. Whether one could keep one's drinking or drugging under control, the easily achieved but artificial highs and lows of drug use were seen as weakening a person's character and subverting their ethical vision.[141] Such purely moral arguments against drugs obviously do not resonate in an era when legal drugs are celebrated as a way to meet every need, even the age-old problem of simply not being as happy with one's personality as one might like.

141. William Stuntz described this morality in the context of Prohibition. "It was also a moral crusade to stamp out behavior that its proponents thought wrong, in the way that escapism and self-damage are often thought wrong." Stuntz, *supra* note 4, at 1842. Stuntz sees Prohibition as collapsing in part because it was enforced inequitably against the lower classes, and he surmises that the reason our current cocaine prohibition has not collapsed is that "[t]olerance of upperclass violators is not nearly so great for cocaine today as it was for alcohol seventy years ago." *Id.* Part of the point of the preceding discussion, of course, is that the upper classes simply have many more options among legal drugs than previously, and that the norms regulating legal drug use have grown fuzzy.

D. The Epidemiological Morality of Drug Prohibition

The drug wars of the twenties drew on the remnants of a quasi-Victorian moral framework that worshipped self-restraint. In the absence of a robust cultural norm of self-restraint and in the midst of widespread legal drug taking, the prevailing arguments against illegal drug use depend heavily on notions of harm. Illegal drug use is seen as wrong because illegal drugs are dangerous, not because nonmedical drug taking is considered immoral per se.

This more instrumental view of illegal drug use, however, ultimately wraps back around into a moral view. The stronger and more obvious the causal relationship between certain drugs and certain harms, the more that use of the drug is seen as being not just a bad idea but morally wrong. Under prevailing attitudes, the person who picks up a crack pipe, whether out of despair, loneliness, or simple boredom, is already on notice that she is endangering the well-being of loved ones and fellow community members. The crack-smoking mom is on notice that she has a good chance of becoming addicted, and that once addicted she has a good chance of neglecting her children. The crack-smoking inner-city youth is on notice that he may end up robbing or hurting to support his habit. In this view, addiction usually serves as an important intermediate link in the causal chain between drug use and most of the social harms that are presumed to flow from such use. Those addicted are thought to be more likely to steal or neglect their children or to suffer health harms themselves than are those who use occasionally.

So the legitimacy of not just prosecuting but incarcerating drug users ultimately rests on the existence of a "common sense" about the harms of illegal drug use. You become deserving of severe punishment when you pick up a crack pipe because it is obvious that you risk doing bad things once you begin smoking crack, even though you may pick up a crack pipe for the same reasons that some pick up a beer. But what is the nature of this "obviousness" that forms the basis for this "common sense" distinction between smoking crack and having a beer? Ultimately, the perceived immorality of crack use turns on assumptions about the probabilities of addiction and its related problems. How likely are you to become addicted if you smoke crack, and what harms are you likely to suffer or inflict once addicted?

Given the varieties of human experiences with drugs, this question is ultimately an epidemiological one. If one hundred people take a hit on a crack pipe, how many are likely to become addicted? This epidemiological dimension also lies underneath much of our concern about the threat to public order posed by drugs. You, personally, may or may not suffer or inflict great harm if you use illegal drugs, but your open use might lead others to use them. The wider that use, the greater the epidemiological risk for society as a whole. If illegal drug use becomes too widespread and too open, then too many people will use them, and of that increased number, too many will become problem users. Or existing users might increase their consumption to the point where they begin to have problems.

In a similar vein, the perceived epidemiological risks of cocaine use for society justify the decisions to send drug offenders to prison. The deterrence and incapacitation effect of such sentences is felt to be necessary because we do not want anyone to use or sell cocaine, even those who might be able to handle its use. In contrast, we would not incarcerate people for long periods of time for a first drunk-driving offense, for example, because for every future recidivist drunk driver you would be taking off the road, you would lock up hundreds of people who would have learned their lesson from a simple fine and who would never have harmed themselves or anyone else.

The problem with this epidemiological drug morality is that the general public's perceptions of the risks of harm of drugs such as crack cocaine are grossly exaggerated, as much good social science research has demonstrated.[142] Crack cocaine provides the best—and most important—example of this phenomenon. In the first place, crack is nowhere near as addicting as popular mythology claims. Cocaine in general has not been shown to be physiologically addicting, and the psychological addiction is less powerful than for many other drugs.[143] For example, in a 1991 study only 5.2% of high school seniors report problems with stopping the use of cocaine after they tried it, a *lower* percentage than for most other drugs.[144] There is also little if any evidence that crack cocaine is more addictive than cocaine in its powder form.[145] What the research does show, however, is that crack smokers are more likely to engage in "binges" during which they use cocaine continuously for a period of time.[146] Such bingeing, while clearly a dangerous and deeply problematic pattern of use, does not necessarily lead to addiction.[147]

Most importantly, however, the social science research refutes the claim that crack use inevitably destroyed the lives of those using it.[148] Instead, the effects of crack use depend heavily on the circumstances of use. This is a dominant theme of much drug research in general, that the "pharmacological properties of a drug do not by themselves determine even a drug's effects, much less the behaviors that sometimes accompany those effects."[149] Rather drug response depends heavily on the circumstances of use.

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142. *See generally* Craig Reinarman & Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare*, *in* CRACK IN AMERICA, *supra* note 7, at 18; Craig Reinarman & Harry G. Levine, *Crack in Context: America's Latest Demon Drug*, *in* CRACK IN AMERICA, *supra* note 7, at 1 [hereinafter Reinarman & Levine, *Crack in Context*].

143. John P. Morgan & Lynn Zimmer, *The Social Pharmacology of Smokable Cocaine: Not All It's Cracked Up To Be*, *in* CRACK IN AMERICA, *supra* note 7, at 131, 147 ("Most cocaine users take the drug occasionally and recreationally—without experiencing compulsion, without bingeing, and without developing symptoms of drug dependence.").

144. *Id.*

145. *Id.* at 143–44.

146. Craig Reinarman et al., *The Contingent Call of the Pipe: Bingeing and Addiction Among Heavy Cocaine Smokers*, *in* CRACK IN AMERICA, *supra* note 7, at 77 [hereinafter Reinarman, et al., *Contingent Call*].

147. *Id.* at 78.

148. *Id.* at 79.

149. Reinarman et al., *Contingent Call*, *supra* note 146, at 9.

> The basic premise of this theory of drug effects is that, in addition to the interaction between the molecules of the substance and the cells of the human body, drug effects are shaped by *the psychological mind-set of the user*—his or her expectations, mood, mental health, purposes, and personality—and by *the social setting of use*—the characteristics of the situation of use, the social conditions that shape such situations and impinge upon the users, and the historically and culturally specific meanings and motives used to interpret drug effects.[150]

One study in particular illustrated the contingency of the harms of crack use. This study focused exclusively on heavy crack users and freebasers and found that even these chronic bingers were able to regulate their use.

> Their unusual desire for crack or freebase always cost them money, often disrupted their relationships and sometimes even caused them problems with their health or their jobs. Ultimately, however, very few of them allowed their craving for crack's intense high to overwhelm their lives. Most eventually cut back or quit precisely because their attachments to conventional life meant more to them than their attachment to the crack high.[151]

Key to the ability of these extreme users to control or quit their bingeing, however, was the fact that most of those interviewed had jobs and conventional lives. It was not just that their "attachments to conventional life" help them to regulate their use: They smoked crack for different reasons that were less likely to lead them to addiction.

> Unlike impoverished, inner-city crack users who face crushing poverty, discrimination, and despair, most of our respondents smoked crack in settings shaped by gainful employment, steady incomes, opportunities, and hope. They were reasonably well bonded to conventional society. The mind-set with which they approached crack or freebase seemed to lean more toward the pursuit of pleasure and excitement than to self-medicating pain and escaping despair. All this appeared to mediate the power of crack and their desire for extreme highs and thus helped them limit the damage that is often associated with heavy crack use.[152]

At this point, the epidemiological morality that we have been discussing runs into serious ethical problems. First, the much-feared harms of crack addiction are limited to a relatively small segment of the population. Second, the probabilities of one's becoming addicted to crack are not randomly distributed. If the poverty of the user makes crack cocaine use riskier, can society ethically incarcerate a drug user essentially because she is poor?[153] The "obviousness" of the harms flowing from taking a hit on a crack pipe have been revealed by social science research to be contingent on factors to which the law should be

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150. *Id*.

151. Reinarman et al., *Contingent Call*, *supra* note 146, at 79–80.

152. *Id*. at 80.

Less research is available on the relationship between crack cocaine and crime. One study of crack related homicides in New York City found that the vast bulk of crack-related homicides occurred between dealers or between dealers and users. Paul J. Goldstein et al., *Crack and Homicide in New York City: A Case Study in the Epidemiology of Violence*, *in* CRACK IN AMERICA, *supra* note 7, at 119, 119. A long-term ethnographic research project confirmed that violence permeates the marketing of crack. "Regular displays of violence are necessary for success in the underground economy—especially the street-level, drug-dealing world of crack." Phillipe Bourgois, *In Search of Horatio Alger: Culture and Ideology in the Crack Economy*, *in* CRACK IN AMERICA, *supra* note 7, at 57, 65.

153. A distinct but related question is whether society can ethically imprison stable middle and upper class users who run relatively little risk of problematic use simply to be consistent.

blind—a contingency that makes incarceration for violation of the law all the more problematic.

> When middle-class Americans become addicted, they have many more resources to use to pull themselves out of trouble and many more opportunities to make a successful life . . . .By contrast, the inner-city poor and working class are far less often employed and more often live at the margins of the conventional order. When their lives become too difficult, they rarely have psychiatrists, but they sometimes self-medicate, escape, or seek moments of intense euphoria with might be called anti*despondents*, such as crack. When some of them become addicted, they have far fewer resources to use to pull themselves out of trouble and far fewer opportunities to make a successful life.[154]

The epidemiological contours of crack addiction provide some justification for the decision to concentrate the attention of law enforcement on crack but does not explain the severity of the punishments imposed. To the degree that mainstream society is in reality relatively immune to the ravages of crack addiction, the public order justification seems somewhat less pressing. Crack use never achieved epidemic proportions and was not contagious in the way that the public readily imagined, so the severity of the current war against drugs is even more inexplicable. Many of the same concerns about social harm prevailed during the drug scare of the 1900s, but the use of incarceration was much lighter.[155] If one puts simple racial animus aside, why have the U.S. public and policy-makers of the 1980s and 1990s imagined the harms of crack cocaine use to be so devastating? Mainstream America always feared the "dangerous classes," but they have never incarcerated them in such numbers.

The severity of the drug policies of the 1980s and 1990s are particularly confounding in light of the larger cultural context described earlier. One would think that a society busily experimenting with all manners of regulated and unregulated mood altering drugs, dietary supplements, herbal remedies, and various enhancement-performing substances would be less likely to imagine that illegal drugs are either more harmful or more addictive than they actually did before. One would also imagine that such a society would be less likely to incarcerate—as opposed to merely prosecute—illegal drug users solely on account of choice of drug. One would, of course, be wrong.

The best non-race-based explanation for why this last drug war has been so severe makes sense of these paradoxes in a different way. Imagining legal drug use to be conducive to a sympathetic and realistic attitude toward illegal drugs assumes that society has become comfortable with its greatly increased used of legal drugs. Yet any major cultural trend is bound to involve anxieties, both among those celebrating the trend as well as among those fearing it. Imagining illegal drug use to be more harmful than it actually is may reflect lingering anxieties about the growing use of psychoactive medications, unregulated herbal supplements, and other legal drugs. The one point upon which both celebrants and critics of the new era in pharmacology could come together

154. Reinarman & Levine, *Crack in Context*, *supra* note 142, at 13 (emphasis in original).
155. *See supra* Part II.

might be the condemnation of illegal drugs. Mandating severe punishment for illegal drug use is one way to affirm that even in this drug-store society, the norms of self-restraint and self-control so necessary for orderly social life have not lost all of their authority. To put it another way, the fuzzier and weaker the non-legal norms regulating legal drug use, the greater the need to etch in sharp relief prohibitions against illegal drug use. In sum, draconian punishment of illegal drug use has compensated for the greatly expanded use of legal drugs during the 1980s and 1990s.

If I am correct in describing this complementary relationship between *laissez-faire* legal drug use on the one hand and draconian punishment of illegal drug use on the other, then the disproportionate prosecution and incarceration of racial minorities such as African Americans may be an essential element of this dysfunctional dynamic. Whereas the drug wars of the twenties were waged within the tattered remnants of that society's Victorian moral framework, the only moral framework restraining drug use today is the epidemiological one described. Our current drug war depends even more heavily than its predecessor on the intellectual and emotional distance that racial difference affords, because the immorality of taking drugs to solve non-medical problems hinges on questions about the harmfulness of the drugs. To give your own child Ritalin and to send another person's child to prison for using cocaine while you yourself are using Prozac requires that you see the other in fundamentally different terms. It requires that you imagine the other would knowingly take a terrible drug that would obviously render whoever takes it a danger to self and others. Unfortunately, race still affords many people the requisite level of detachment to imagine the harms and corresponding immorality of illegal drug use as being so much greater than they actually are.

IV

CONCLUSION

Plaintiffs in a civil case for employment or housing discrimination typically enjoy the benefit of a presumption of disparate treatment once they have demonstrated the disparate impact of a particular policy or decision. Perhaps, the history of disparate severity in our former and current drug wars should entitle African Americans to a presumption that drug wars that disproportionately impact them may be overly punitive. For cultural reasons, we tend too often to see drug wars in terms of black and white, in both senses of the phrase.